



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

**Requestor Name**

ERIC A VANDERWERFF DC

**Respondent Name**

NEW HAMPSHIRE INSURANCE CO

**MFDR Tracking Number**

M4-14-3261-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

JUNE 30, 2014

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "The carrier, AIG, has originally denied the services (98940, 98943) rendered on 11/6/13, 11/18/13, 12/2/13, and 12/4/13 based on the **denial codes (97) and MV00**) as listed above. These are false denials."

**Amount in Dispute:** \$250.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "New Hampshire Insurance Company is maintaining their position that the additional \$250.00 for the 11/6/13, 11/18/13, 12/2/13 and 12/4/13 dates of service is not owed to the requestor, Eric VanderWerff, DC because the bill has been paid in accordance with State Fee Guidelines. The bills were submitted one time, reviewed and paid. On 1/17/2014 a check was issued in the amount of \$616.90 for the 11/6-11/18/13 dates of service. On 1/24/2014 a check in the amount of \$69.32 was issued and another check was issued on 2/14/2014 for \$199.68 for the 12/2/13 and 12/4/13 dates of service."

**Response Submitted by:** AIG Services

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 6, 2013 through December 4, 2013	CPT Code 98940 (X4 Dates) Chiropractic manipulative treatment (CMT); spinal, 1-2 regions	\$50.00 X 4 = \$200.00	\$168.60
December 4, 2013	CPT Code 98943 Chiropractic manipulative treatment (CMT); Extraspinal, 1 or more regions	\$50.00	\$0.00
TOTAL		\$250.00	\$168.60

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.1, effective March 1, 2008, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- The amount paid reflects a fee schedule reduction.
- MV00-Per CPT, code is denied based on the actual CPT code definition. Service included in 97140.
- B291-This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed.
- W1-Workers compensation fee schedule adjustment.

### **Issues**

1. Is the allowance of CPT code 98940 included in the allowance of another service billed on the disputed date?
2. Is the requestor due reimbursement for CPT code 98940?
3. Is the allowance of CPT code 98943 included in the allowance of another service billed on the disputed date?
4. Is the requestor due reimbursement for CPT code 98943?

### **Findings**

1. CPT Code 98940 is defined as "Chiropractic manipulative treatment (CMT); spinal, 1-2 regions."
  - The requestor billed 4 units of CPT code 98940 from November 16, 2013 through December 4, 2013.
  - The respondent denied reimbursement based upon reason codes "97" and "MV00."
  - Per 28 Texas Administrative Code §134.203(b)(1) "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
    - (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."
  - On the disputed dates of service the requestor billed CPT codes: 98943, 98940, G0283, 97140, and 97110.
  - Per CCI edits, CPT code 98940 is not a component of any of the services rendered on the disputed date; therefore, the respondent's denial based upon reason codes "97" and "MV00" is not supported.
2. Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
  - (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.
  - (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2013 DWC conversion factor for this service is 55.3.

The Medicare Conversion Factor is 34.023

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75061 in Irving, Texas. Per

Medicare the provider is reimbursed using the locality of Dallas, Texas.

Using the above formula the Division finds the following:

CODE	No. of Units Billed	Medicare Participating Amount	TOTAL MAR	TOTAL PAID	AMOUNT DUE
98940	4	\$25.93	$\$42.15 \times 4 = \$168.60$	\$0.00	\$168.60

3. CPT Code 98943 is defined as “Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions.”

- The requestor billed for one unit of code 98943 on December 4, 2013.
- The respondent denied reimbursement based upon reason codes “97” and “B291.”
- Per CCI edits, CPT code 98943 is not a component of any of the services rendered on the disputed date; therefore, the respondent’s denial based upon reason codes “97” and “B291” is not supported.

28 Texas Administrative Code §134.203 (f) For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement). CPT code 98943 does not have a relative value unit assigned; therefore, reimbursement shall be provided in accordance with 28 Texas Administrative Code §134.1.

28 Texas Administrative Code §134.1(e)(3) states “in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section.

28 Texas Administrative Code §134.1 (f)(1-3) states “Fair and reasonable reimbursement shall:

- (1) be consistent with the criteria of Labor Code §413.011;
- (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
- (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.”

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable.” Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for CPT code 98943 would be a fair and reasonable rate of reimbursement. As a result, payment cannot be recommended.

## **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$168.60.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$168.60 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

### Authorized Signature

_____	_____	08/28/2014
Signature	Medical Fee Dispute Resolution Officer	Date

## YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**